



INSTRUCTIONS:

INITIAL APPROVAL OF ADVANCED PRACTICE NURSING CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) OR CERTIFIED NURSE MIDWIFE (CNM)

1. Licensure as a Registered Nurse in Alabama is required for approval to practice as an advanced practice nurse and for subsequent renewal of APN approval. This application form is specifically for the applicant for first-time approval by the Alabama Board of Nursing. Do not use this application to apply for changes in collaborative practice after initial approval.
2. The requirements for Advanced Practice Nursing as CRNP and CNM are posted: www.abn.alabama.gov
> Nurse Practice Act > Article 5 Advanced Practice Nursing, and
> Alabama Board of Nursing Administrative Code > Chapter 610-X-5 Advanced Practice Nursing – Collaborative Practice, and Chapter 610-X-2-.05 Definitions, Advanced Practice Nursing.
These regulations are jointly adopted with the Alabama Board of Medical Examiners, Administrative Rules for physicians, Chapter 540-X-8 Advanced Practice Nursing www.albme.org

Educational and Certification Requirements for Advanced Practice Nursing

Specialty	Education: Official transcript from school	Certification: Official verification from certifying agency.
CNM	Graduation from a nurse midwifery education program and master's or higher degree in nursing. ABN Administrative Code 610-X-5-.13	ACNM Certification Council
CRNP	Graduation from a nurse practitioner educational program and master's or higher degree in nursing. ABN Administrative Code 610-X-5-.03	Certification as a nurse practitioner in the specialty consistent with NP education from a national certifying body recognized by the Alabama Board of Nursing.

3. Print legibly in black ink or type the required information on this form. The CRNP/CNM applicant is responsible for the truth and accuracy of the completed application. Illegible or incomplete applications will be returned to the CRNP/CNM applicant.
4. Keep a copy of the signed application for your records. The Board of Nursing charges a fee for copies of documents on file.
5. **APPLICATION FEES are not refundable. Send payment to the Alabama Board of Nursing** with the application. The applicant may pay by personal check printed with the applicant's name and Alabama address on an account with an **in-state Alabama bank**. Business checks are accepted.
Refer to Alabama Administrative Code Chapter 610-X-4-.13 for restrictions on forms of payment.
Personal checks are not accepted from:
 - A. Third person paying the applicant's fee.
 - B. Applicant with an out of state address of residence.
 - C. Out-of-state bank account.
6. Complete the APPLICATION FOR INITIAL APPROVAL FOR ADVANCED PRACTICE NURSING AS A CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) OR CERTIFIED NURSE MIDWIFE (CNM) including the PROTOCOL AND FORMULARY. Fee = \$150.00, payable to the Alabama Board of Nursing. If incomplete, the application(s) and the attached fee(s) will be returned to the **nurse applicant, regardless of the source of payment**. This application form is specifically for the applicant who has never held approval by

the Alabama Board of Nursing for practice as a CRNP or CNM. Do not use this application to apply for changes in collaborative practice after initial approval as a CRNP or CNM. Additional pages, if submitted, must be identified with the name and license number of both the CRNP/CNM and the collaborating physician.

7. Request the academic institution(s) that granted your degree and/or certificate to send an official transcript to the Alabama Board of Nursing. Transcripts must be received in a sealed envelope from the institution that granted your degree/certificate. MSN with post-master's certificate requires transcript for both programs.
8. Request the certifying agency to send the Alabama Board of Nursing verification of your specialty certification with starting and expiration dates. Continued certification is required to maintain approval for advanced practice nursing. It is the applicant's responsibility to have the certifying agency send official verification of recertification.
9. Submit a separate application for **each additional collaborating** physician, using the APPLICATION TO ADD OR CHANGE COLLABORATIVE PRACTICE AS A CERTIFIED REGISTERED NURSE PRACTITIONER (CRNP) OR CERTIFIED NURSE MIDWIFE (CNM). Fee = \$50.00. Additional pages, if submitted, must be identified with the name and license number of both the CRNP/CNM and the collaborating physician.
10. Applications are processed based on "first in, first out." Allow at least two weeks for a response to your application.
11. If you want verification of delivery to the Alabama Board of Nursing, please request this service from the US Postal Service or letter delivery service (FedEx, DHL, etc.) before you mail the application. The volume of incoming mail makes it impractical to respond to phone calls for immediate confirmation of mail delivery.

<p>Send the signed original application and supporting documents with \$150.00 payable to:</p> <p>Alabama Board of Nursing P. O. BOX 303900 Montgomery AL 36130-3900</p>	<p>Express Delivery should be addressed to:</p> <p>Alabama Board of Nursing 770 Washington Ave, Suite 250 Montgomery AL 36104-3816</p>
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12. **The Collaborating Physician is required to notify the Alabama Board of Medical Examiners** within five (5) business days of commencing or terminating collaborative practice with a CRNP or CNM. A notification form is included with this application as a convenience. Send only the notification form to the Alabama Board of Medical Examiners.
13. Temporary Approval. All applications are reviewed for Temporary Approval or Interim Approval, as defined in Alabama Board of Nursing Administrative Code 610-X-5-.07 (CRNP) and 610-x-5-.17 (CNM). After the application meets all applicable requirements, the Board of Nursing will send written verification of Temporary Approval or Interim Approval to the applicant CRNP/CNM and the collaborating physician.
14. Applications that qualify for Temporary or Interim Approval are listed for review at the next scheduled meeting of the Joint Committee of the Alabama Board of Nursing and Alabama Board of Medical Examiners. Scheduled meeting dates are posted on the website of the Alabama Secretary of State www.sos.state.al.us > Open Meetings Act.

<p>This tentative schedule is provided for planning purposes only. Adjustments to this schedule may occur at the discretion of the Board.</p>	
If Temporary or Interim Approval is issued by this date or the last business day prior to:	The application will be posted for review at the next scheduled meeting:
February 15, or earlier	March
April 15, or earlier	May
June 15, or earlier	July
August 15, or earlier	September
October 15, or earlier	November

15. Notice of Approval for Practice will be mailed to **your current address on file** with the Alabama Board of Nursing. **Mail from the Alabama Board of Nursing is not forwarded by the US Postal Service.** If the letter cannot be delivered as addressed, it is returned to the Board of Nursing. The Board charges a fee of \$25.00 to re-mail a document that was returned because it could not be delivered as addressed.
16. The RN may update the personal mailing address and record name changes on the ABN website www.abn.alabama.gov > On-Line Services. For name changes, submit a copy of the court order, marriage license or divorce decree authorizing the change in your name.
17. **Provisional Approval for Advanced Practice Nursing.** (No additional fee) The applicant who has met all requirements for the first attempt on the national certification examination may apply for Provisional Approval. Request the certifying agency to notify the Alabama Board of Nursing of your official eligibility or authorization to take the examination. Provisional Approval is limited to one year, and **expires with the results of the first examination attempt, and cannot be renewed or re-issued with a subsequent application.** Refer to 610-X-5-.07 and 610-X-5-.17 for details.
18. The Advanced Practice Nursing applicant for **RN License by Endorsement from Another State** may apply for approval of Advanced Practice Nursing during the period of the TEMPORARY RN PERMIT. A temporary permit or Active Alabama RN license is required prior to approval for Advanced Practice Nursing.
19. Exemptions from Collaboration with an Alabama physician are allowed for:
 - A. Faculty in a nurse practitioner education program. Submit pages 1 and 10 of the application. Request confirmation of faculty status on institutional letterhead from the Dean/Program Director, mailed to the Alabama Board of Nursing.
 - B. CRNP or CNM employed in a federal facility. Provide license information from the collaborating physician's state of licensure. Submit all sections of the application and protocol.

20. SECTIONS OF THE COLLABORATION PROTOCOL

- A. **Employer:** If the physician is not the employer, list the name and full address of the employer.
- B. **Physician Information.** Complete all items. Mark N/A if it does not apply.
 - 1) Outline the plan for physician availability and emergency medical intervention.
- C. **Limit on CRNPs/CNMs/PAs per Physician.** List the names and **scheduled working hours** per week for all CRNPs, CNMs, and PAs, including other pending applicants, in practice with this physician.
 - 1) If the total exceeds 120 scheduled weekly practice hours, review the rules for limits on CRNP/CNM/PA personnel with one physician: ABN Administrative Code Chapter 610-X-5-.03 & .04 for CRNP, 610-X-5-.14 & .15 for CNM.
 - 2) The physician is required to notify the Alabama Board of Medical Examiners within in five (5) business days of the commencement or termination of collaborative practice.
A form is provided for the physician's report to the Board of Medical Examiners.
- D. **Sites:** List **every collaborative practice site** where the applicant will practice under this protocol. Identify hospitals and skilled nursing facilities by checking the box to the right of the address. Refer to Alabama Board of Nursing Administrative Code for definitions, collaboration requirements and exemptions to on-site collaboration
 - 1) Definitions: Chapter 610-X-2-.05 (1)- (17)
 - 2) CRNP: Chapter 610-X-5-.08
 - 3) CNM: 610-X-5-.19
- E. **Protocol:** The standard protocols for CRNP and for CNM are included in the application.
Additional duties may be requested as provided in Alabama Board of Nursing Administrative Code Chapter

610-X-5-.10 for the CRNP and 610-X-5-.21 for the CNM. Attach the proposed protocol for each procedure. Prior to performing the procedure, you must submit documentation of the training and/or certification with supervised clinical practice that qualifies you to perform each function/procedure that you request. Use additional pages as needed, identified with the name and license number of both the CRNP/CNM applicant and the collaborating physician.

F. Formulary:

- 1) The Standard Formulary for CRNP and CNM is listed by drug classification.
- 2) If the proposed collaboration protocol of this CRNP/CNM applicant includes specific restrictions on individual drug classifications in the Standard Formulary, state the restriction on the Formulary page.
- 3) If requesting prescribing authority for any of the following classifications (items 26 – 30 on the formulary page) attach a description of the patient population, disease process or other circumstances for CRNP/CNM prescribing in drug classifications. Specify the restrictions within the protocol for this CRNP/CNM applicant.
 26. **Antineoplastic agents**
 27. **Heavy metals**
 28. **Gold Compounds**
 29. **Oxytocics for CRNP**
 30. **Radioactive Agents** *If requested, attach a copy of the **physician's current license from the Alabama Department of Public Health for prescribing/dispensing radioactive pharmaceuticals**. Attach the prescribing protocol for the applicant with this physician.*
- 4) For other drug classifications that are not listed on the application, attach a page with your request and the protocol for prescribing in the proposed collaboration.

G. Quality Monitoring: Refer to the Alabama Board of Nursing Administrative Code Chapter 610-X-5-.10 (4) for CRNP and 610-x-5-.21 (4) for CNM.

- 1) Specify a plan for quality assurance management with established patient outcome indicators for evaluation of the clinical practice of the certified registered nurse practitioner. Quality assurance monitoring may be performed by designated personnel, with final results presented to the physician and certified registered nurse practitioner for review.
- 2) Include review of no less than ten percent (10%) of medical records plus all adverse outcomes.
- 3) Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings, conclusions, and, if indicated, recommendations for change.

H. Signatures: Original signatures are required.

For more information, refer to the website of the Alabama Board of Nursing www.abn.alabama.gov

PHONE: 334-242-4060 or TOLL FREE: 1-800-656-5318

or the Alabama Board of Medical Examiners www.albme.org PHONE: 334-242-4116

PHYSICIAN'S NOTICE OF

(Check One)

☐ **COMMENCEMENT** ☐ **TERMINATION**

IN COLLABORATIVE PRACTICE

- A. This form is provided as a convenience for the collaborating physician. Send **this page only** to the **Alabama Board of Medical Examiners** by e-mail, facsimile, overnight delivery or U.S. mail within five (5) business days of starting or ending a collaborative practice with CRNP or CNM.
- B. Submit the application for Initial Approval for Advanced Practice Nursing as a CRNP or CNM with the collaborative practice protocol to the Alabama Board of Nursing, with the fee payable to the Alabama Board of Nursing.

SEND THIS PAGE ONLY TO: Alabama Board of Medical Examiners

ATTN: Cheryl Thomas, RN, MSM, Collaborative Practice Inspector

EMAIL: cthomas@albme.org

FAX: 334-240-3037

Overnight Delivery: 848 Washington Ave, Montgomery, AL 36104

US Mail: P. O. BOX 946, Montgomery, AL 36101-0946

Physician's Name _____ License Number _____

Practice Address _____

1. CRNP/CNM Name _____ License Number _____

CRNP/CNM Practice Address _____

CRNP/CNM **started** providing services under the collaborative practice agreement on date: _____

CRNP/CNM **ceased** providing services under the collaborative practice agreement on date: _____

2. CRNP/CNM Name _____ License Number _____

CRNP/CNM Practice Address _____

CRNP/CNM **started** providing services under the collaborative practice agreement on date: _____

CRNP/CNM **ceased** providing services under the collaborative practice agreement on date: _____

This is to certify that I, the undersigned physician, have read and understand the Alabama Board of Medical Examiners Rules, Chapter 540-X-8, Advanced Practice Nursing: Collaborative Practice. I also understand that failure to adhere to the rules may result in an action against my license.

PHYSICIAN'S SIGNATURE: _____

DATE _____



Alabama Board of Nursing

Initial Approval for Advanced Practice Nursing

Check (✓) the specialty for this application.

☐ CRNP \$150

☐ CNM \$150

Date Received



Mailing address:
P. O. BOX 303900
Montgomery AL 36130-3900

Physical address:
770 Washington Ave, Suite 250
Montgomery AL 36104-3816

PHONE: 334-242-4060 TOLL FREE: 1-800-656-5318

For more information, refer to our website at www.abn.alabama.gov

Date Approved

Send the signed original application, fee and supporting documents

LEGAL
NAME

Last First Middle Maiden

LIST ANY PREVIOUSLY USED NAMES / ALIASES _____

SOCIAL SECURITY NUMBER _____ ALABAMA RN LICENSE NUMBER _____

PERMANENT STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

DAYTIME PHONE _____ FAX _____

OTHER PHONE _____ EMAIL _____

Advanced Practice Nursing Education

SCHOOL/COLLEGE (Name, City, State)

DEGREE /CERTIFICATE GRADUATION (month, year)

CERTIFICATION FOR ADVANCED PRACTICE NURSING:

I have requested the certifying organization to send the Alabama Board of Nursing official verification of my current certification in the specialty listed below.

YES NO
☐ ☐

I have requested the certifying organization to send the Alabama Board of Nursing confirmation of Eligibility/Authorization to Test for the exam listed below:

YES NO
☐ ☐

CERTIFYING ORGANIZATION	SPECIALTY	START AND EXPIRE DATES <input type="checkbox"/> Or Date(s) for Scheduled Exam <input type="checkbox"/>

I request **PROVISIONAL APPROVAL** pending results of first attempt on certification examination.
I understand the requirement for on-site supervision.

YES NO
☐ ☐

Name and license number of (a) supervising APN with same specialty
certification &/or (b) supervising physician:

Employer and Clinical Agency for provisional practice

YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION!

AFFIDAVIT FOR AFFIRMATION OF ELIGIBILITY FOR ADVANCED PRACTICE NURSING

I affirm that the information recorded on this application concerning any item contained herein is true and correct. I understand that I may be required to submit documentation to support my affirmation. I further understand that any false statement is in violation of the Code of Alabama and the Board of Nursing Administrative Code and constitutes cause for disciplinary action.

(Signature of Applicant)

(Date)

CRNP/CNM Name and License Number _____

Section A. APPLICANT'S EMPLOYER FOR THIS COLLABORATION:

Agency Name: _____
Address, City, State, ZIP _____
Telephone Number: _____

Section B. PHYSICIAN INFORMATION

1. Collaborating Physician: _____
Print Name As Shown On Physician's Medical License MD/DO Lic Numr
2. Medical Specialty of Collaborating Physician: _____
3. Is Physician Board Eligible/Certified? Yes ☐ No ☐ Certificate Number: _____
4. Type of Practice: _____
5. Physician's Principal Practice Location
Address: _____

6. Physician's Mailing Address
(if different from Practice Address): _____
7. Physician's
Telephone
Number: _____ Physician's Email Address: _____
8. Starting date for this collaborative practice: _____
9. Total hours per week will CRNP/CNM applicant will be routinely scheduled
in this collaborative practice, including all sites, excluding time on call. TOTAL WEEKLY HOURS: _____
10. Will the CRNP / CNM practice in the physician's principal practice site? ☐ Yes, routinely ☐ No
☐ Yes, rarely or as needed
11. Minimum number of hours per week the collaborating physician or an authorized
covering physician will be present with this CRNP/CNM in a practice site listed in this
protocol, cumulative per week for all sites. MINIMUM With Physician: _____
12. How is the collaborating or covering physician available for consultation and/or referral when not present on-site with the
CRNP/CNM?

13. How will patients receive medical intervention during hours when the site is closed?

14. How will patients receive medical intervention in emergency situations?

Section C. LIMIT ON CRNPs/CNMs/PAs PER PHYSICIAN.

List the names, license numbers, and total scheduled hours per week for all CRNPs/CNMs/PAs, **including all other pending applicants**, who will be in collaborative practice with this collaborating physician. The physician is limited to 120 scheduled hours will all CRNP, CNM, and PA personnel. The total does not apply to Covering (back-up) for other collaborating physicians.

Name	License Number	Maximum Hours Scheduled per week in Collaboration with this Physician
TOTAL		

Section D. PRACTICE SITES

Duplicate this page as needed. Include the CRNP/CNM and physician license numbers on attachments.

List every collaborative practice site where the applicant will practice under this protocol. Identify acute care hospitals, licensed skilled nursing facilities, assisted living facilities and special care assisted living facilities by checking the box in the respective column.		Hospital or SNF	ALF or SCALF
Physician's Principal Practice Site	1.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	2.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	3.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	4.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	5.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	6.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	7.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	8.		
Physical Address			
City ZIP			
Telephone			
Practice Site Name	9.		
Physical Address			
City ZIP			
Telephone			

Section E:**CERTIFIED REGISTERED NURSE PRACTITIONER PROTOCOL**

1. The certified nurse practitioner (CRNP) may work in any setting consistent with the collaborating physician's areas of practice and function within the CRNP's specialty scope of practice. The CRNP's scope of practice shall be defined as those functions and procedures for which the CRNP is qualified by formal education, clinical training, area of certification and experience to perform.

2. The following represents the functions which may be performed by the CRNP:

A. Perform complete, detailed and accurate health histories, review patient records, develop comprehensive medical and nursing status reports, and order laboratory, radiological and diagnostic studies appropriate for complaint, age, race, sex and physical condition of the patient.

B. Perform comprehensive physical examinations and assessments and record pertinent data in appropriate medical records.

C. Formulate medical and nursing diagnoses and institute therapy or referrals of patients to the appropriate health care facilities, agencies, other resources of the community or physician.

D. Plan and initiate a therapeutic regimen which includes ordering legend drugs, medical devices, nutrition and supportive services.

E. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, allergic reactions and emergency obstetric delivery.

F. Arrange inpatient admissions and discharges at the direction of the collaborating physician; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records; issue diagnostic and therapeutic orders including orders for legend drugs, which must be signed within specified time period as defined by agency policy and/or applicable legal regulations and accreditation standards.

G. Interpret and analyze patient data to determine patient status, patient management and treatment.

H. Provide instructions and guidance regarding health care and health care promotion to patients/family/ significant others.

I. In addition to functions/procedures within the scope of RN practice, perform or assist with laboratory procedures and technical procedures, which include but are not limited to the following:

Biopsy of superficial lesions

Suturing of superficial lacerations

Management and removal of arterial and central venous lines

Debridement of wounds

Aspiration, incision and drainage of superficial lesions

Foreign body removal

Initial x-ray interpretation, with subsequent required physician interpretation

Cast application/removal

J. Additional duties requested for the CRNP (i.e., diagnostic or therapeutic procedures requiring additional training) as provided in ABN Administrative Code Chapter 610-X-5-.10 (3). See directions with this form for documentation of instruction and practice.

Function	What Documentation Is Attached?

Section E:**CERTIFIED NURSE MIDWIFE PROTOCOL**

1. The certified nurse Midwife (CNM) may work in any setting consistent with the collaborating physician's areas of practice and function within the CNM's specialty scope of practice. The CNM's scope of practice shall be defined as those functions and procedures for which the CNM is qualified by formal education, clinical training, area of certification and experience to perform.

2. The following represents the functions which may be performed by the CNM:

A. Perform complete, detailed and accurate health histories, review patient records, develop comprehensive medical and nursing status reports, and order laboratory, radiological and diagnostic studies appropriate for complaint, age, race, sex and physical condition of the patient.

B. Perform comprehensive physical examinations and assessments and record pertinent data in appropriate medical records.

C. Formulate medical and nursing diagnoses and institute therapy or referrals of patients to the appropriate health care facilities, agencies, other resources of the community or physician.

D. Plan and initiate a therapeutic regimen which includes ordering legend drugs, medical devices, nutrition and supportive services.

E. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, allergic reactions and emergency obstetric delivery.

F. Arrange inpatient admissions and discharges in accordance with established guidelines/standards developed within the collaborative practice; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients; medical records; issue diagnostic and therapeutic orders including orders for legend drugs, which must be signed within specified time period as defined by agency policy and/or applicable legal regulations and accreditation standards; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records; issue diagnostic and therapeutic orders including orders for legend drugs, which must be signed within specified time period as defined by agency policy and/or applicable legal regulations and accreditation standards.

G. Interpret and analyze patient data to determine patient status, patient management and treatment.

H. Provide instructions and guidance regarding health care and health care promotion to patients/family/ significant others.

I. In addition to functions/procedures within the scope of RN practice, perform or assist with laboratory procedures and technical procedures, which include but are not limited to the following:

Bimanual pelvic examination	Episiotomy
Insertion of intrauterine devices	Episiotomy and laceration repair
Fit diaphragms	Management of abnormal birth events until physician arrives
Amniotomy	Manual removal of placenta
Local and pudendal anesthesia	Uterine exploration
Spontaneous vaginal delivery	

J. Additional duties requested for the CNM (i.e., diagnostic or therapeutic procedures requiring additional training) as provided in ABN Administrative Code Chapter 610-X-5-.21 (3). See directions with this form for documentation of instruction and practice..

Function	What Documentation Is Attached?

Section F. Standard Formulary of Legend Drug Classifications for CRNP and CNM
Prescriptive authority for CRNP and CNM does not include controlled substances in any schedule.

If a drug classification is specifically restricted in this collaborative practice protocol, check (✓) the box and state restrictions in area provided or on additional pages as needed for legibility. Authorized categories of drugs should reflect the needs of the medical practice in which the CRNP/CNM is working.

All written prescriptions must adhere to the standard, recommended doses of legend drugs, as identified in the Physicians' Desk Reference or the product information insert, not to exceed the recommended treatment regimen periods.

Medication	If restricted, check this box.	State the Restrictions
1. Antihistamines and Decongestants	<input type="checkbox"/>	
2. Analgesics and Antipyretics	<input type="checkbox"/>	
3. Blood Derivatives	<input type="checkbox"/>	
4. Coagulation Agents	<input type="checkbox"/>	
5. Central Nervous System Agents	<input type="checkbox"/>	
6. Agents of Electrolytic, Caloric and Water Balance	<input type="checkbox"/>	
7. Expectorants and Cough Preparation	<input type="checkbox"/>	
8. Gastrointestinal Drugs	<input type="checkbox"/>	
9. Local Anesthetics	<input type="checkbox"/>	
10. Pulmonary Drugs	<input type="checkbox"/>	
11. Spasmolytics	<input type="checkbox"/>	
12. Vitamins	<input type="checkbox"/>	
13. Anti-Infective Agents	<input type="checkbox"/>	
14. Autonomic Drugs	<input type="checkbox"/>	
15. Blood Formation	<input type="checkbox"/>	
16. Cardiovascular Drugs	<input type="checkbox"/>	
17. Diagnostic Agents	<input type="checkbox"/>	
18. Enzymes	<input type="checkbox"/>	
19. Ophthalmic Drugs	<input type="checkbox"/>	
20. Anti-Inflammatory Drugs	<input type="checkbox"/>	
21. Hormone and Synthetic Drugs	<input type="checkbox"/>	
22. Birth Control Drugs and Devices	<input type="checkbox"/>	
23. Serums, Toxoids, Vaccines	<input type="checkbox"/>	
24. Prosthetics/Orthotics	<input type="checkbox"/>	
25. OXYTOCICS for CNM: <i>may be prescribed according to protocols for management of post-partum bleeding, and in concurrent consultation with the physician for augmentation of labor.</i>		

NOTE: Refer to instruction page regarding items 26-30. If requested and approved for this applicant, the following drugs may be prescribed within the limitations defined below by the Alabama Board of Nursing and the Alabama Board of Medical Examiners. Initial each classification that you are requesting.

		CRNP/CNM	MD/ DO
26.	ANTINEOPLASTIC AGENTS: <i>Initial dose must be prescribed by a physician, with authorization to prescribe continuing maintenance doses according to written protocol or direct order of the physician.</i>		
27.	HEAVY METALS: <i>Initial dose must be prescribed by a physician with authorization from the collaborating physician to prescribe continued maintenance dosages.</i>		
28.	GOLD COMPOUNDS: <i>Initial dose must be prescribed by a physician with authorization from the collaborating physician to prescribe continued maintenance dosages.</i>		
29.	OXYTOCICS for CRNP – <i>may be prescribed only in consultation with the physician.</i>		
30.	RADIOACTIVE AGENTS: <i>If requested, attach a copy of the physician's current license from the Alabama Department of Public Health for prescribing/dispensing radioactive pharmaceuticals. Attach the prescribing protocol for the applicant with this physician.</i>		
31.	Other: See instruction page.		

Section G: QUALITY ASSURANCE PLAN**ABME Rule 540-X-8-.01 and ABN Rule 610-X-2-.05**

(12) Medical Oversight: Concurrent and on-going collaboration between a physician and a CRNP or CNM and documentation of time together in a practice site; may include but is not limited to direct consultation and patient care, discussion of disease processes and medical care, review of patient records, protocols and outcome indicators, and other activities to promote positive patient outcomes.

(13) Quality Assurance: Documented evaluation of the clinical practice of the certified registered nurse practitioner or certified nurse midwife against established patient outcome indicators, using a specified percentage or selected sample of patient records, with a summary of findings, conclusions, and, if indicated, recommendations for change.

ABME Rule 540-X-8-.08 (9) (g) & ABN Rule 610-X-5-.08 (9) for CRNP**ABME Rule 540-X-8-.22 (9) (g) & ABN Rule 610-X-5-.19 (9) (g) for CNM**

(g) Specify a plan for quality assurance management with established patient outcome indicators for evaluation of the clinical practice of the certified registered nurse practitioner/certified nurse midwife and include review of no less than ten percent (10%) of medical records plus all adverse outcomes. Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings, conclusions, and, if indicated, recommendations for change. Quality assurance monitoring may be performed by designated personnel, with final results presented to the physician and certified registered nurse practitioner for review.

Check at least one item in the three components of Quality Assurance plan listed below.

Review and sign the acknowledgements on the Collaboration Agreement page.

A. MECHANISM FOR REVIEW OF MEDICAL RECORDS

- ☐ Agency/facility committee
- ☐ Certified registered nurse practitioner/collaborating physician jointly
- ☐ Collaborating physician
- ☐ Quality Assurance professional
- ☐ Any of those listed above
- ☐ Other (specify): _____

B. TIME FRAME FOR REVIEW

- ☐ Weekly
- ☐ Monthly
- ☐ Other (specify): _____

C. RECORDS REVIEWED – Selected from patients treated by the CRNP/CNM

Review of 100% of records for patients with adverse outcomes is required.

- ☐ **10 % random sampling of all patient records is required within the designated calendar interval.**
- ☐ _____% Random sampling of all records of patients. **Specify percentage.**
- ☐ Other. Describe criteria for selecting records to be reviewed.

COLLABORATION AGREEMENT FOR CRNP/CNM AND PHYSICIAN

The application requires the signatures of the CRNP/CNM applicant and collaborating physician.

Acknowledge each statement with your initials . Sign your name below .	CRNP/ CNM	MD/ DO
PRESCRIBING AUTHORITY: I request authorization for prescriptive privileges for CRNP and CNM named in this document and collaboration protocol using the Standard Formulary of Legend Drug Classifications? Specified restrictions on drug classifications for our protocol, if any, are noted on the enclosed Standard Formulary		
I am aware the Alabama Controlled Substances list includes some medications that are not controlled by the Drug Enforcement Administration, and are not marked by the manufacturer with the symbol to indicate the control schedule. I am familiar with the Controlled Substances list posted on the website of the Alabama Department of Public Health www.adph.org		
I acknowledge the CRNP/CNM named in this document is not authorized to prescribe controlled drugs in any schedule.		
I acknowledge the collaborating physician and CRNP/CNM shall be held responsible for any act or omission of the CRNP/CNM arising out of the CRNP's/CNM's prescribing to patients.		
QUALITY ASSURANCE: I have reviewed the regulations pertaining to Quality Assurance and understand my responsibilities for executing the Quality Assurance plan in this document.		

▪ **PROTOCOL FOR COLLABORATION:** We hereby certify under penalty of law of the State of Alabama that the foregoing information in this application is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules and regulations of the state of Alabama pertaining to CRNPs/CNMs and understand our responsibilities. We understand that we are jointly and individually responsible for complying with the rules and regulations pertaining to CRNPs/CNMs and the collaborative practice of CRNPs/CNMs with physicians.

 Print Collaborating Physician's Name

 Signature of Collaborating Physician

 Date

 Print Name of Applicant

 Signature of Applicant

 Date

COVERING PHYSICIAN AGREEMENT

To: Alabama Board of Nursing
Alabama Board of Medical Examiners

As a covering (back-up) physician providing guidance and direction for the applicant named below:

- I hereby affirm that I am familiar with the current regulations regarding ☐ **CRNPs** ☐ **CNMs**, and the collaborative practice protocol filed by the primary collaborating physician.
- I will be accountable for adequately providing oversight of the medical care rendered pursuant to the CRNP/CNM protocol.
- I approved the drug type, dosage, quantity, and number of refills of legend drugs which the CRNP/CNM is authorized to prescribe in the formulary included with the protocol.
- I will assume all responsibility for the medical actions of the CRNP/CNM during the temporary absence of the primary collaborating physician.

Provide the **mailing address for the covering physician(s)** if different from the collaborating physician's address.

Signature of covering (back-up) physician	Date Signed	Name of the covering physician. (Type or print legibly.)	License Number

REQUEST FOR EXEMPTION FROM COLLABORATIVE PRACTICE WITH A PHYSICIAN LICENSED TO PRACTICE MEDICINE OR OSTEOPATHY IN ALABAMA

	YES	NO
I request exemption from collaborative practice with a physician licensed to practice medicine or osteopathy in Alabama.	<input type="checkbox"/>	<input type="checkbox"/>
I am employed as faculty in a nurse practitioner education program.	<input type="checkbox"/>	<input type="checkbox"/>
I have requested written confirmation of faculty status from the dean/ program director of	<input type="checkbox"/>	<input type="checkbox"/>
Name of School _____		
I am employed by the United States government, practicing a federal facility with a physician is who is licensed in another state or US territory.	<input type="checkbox"/>	<input type="checkbox"/>
Name of Facility/Agency _____		
I have requested verification of the physician's state licensure from the licensing Board.		
Physician Name: _____	<input type="checkbox"/>	<input type="checkbox"/>
License Number: _____		
Name of Licensing Board: _____		

_____	_____
Print Applicant Name	License Number
_____	_____
Signature of Applicant	Date